FOR OHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0028076

Facility Name: WATERFRONT TERRACE

Address: 7750 SOUTH SHORE DRIVE (Number) CHICAGO (City) 60649 (Zip Code)

County: COOK

Telephone Number: (847) 679-8219 **Fax #** (847) 679-7377

IDPA ID Number: 36-3230699

Date of Initial License for Current Owners: 04/01/83

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2005 to 12/31/2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) MARSHALL MAUER
(Title) TREASURER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD, 3750 W DEVON, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	42	Skilled (SNF)	42	15,330	1
2		Skilled Pediatric (SNF/PED)			2
3	76	Intermediate (ICF)	76	27,740	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	118	TOTALS	118	43,070	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	627	24	3,665	4,316	8
9	SNF/PED					9
10	ICF	31,110	1,414	125	32,649	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	31,737	1,438	3,790	36,965	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.83%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 04/01/83

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 04/01/83 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 16 and days of care provided 3,665

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	191,050	23,247	9,313	223,610		223,610		223,610			1
2	Food Purchase		157,310		157,310		157,310	(1,609)	155,701			2
3	Housekeeping	41,450	33,698		75,148		75,148		75,148			3
4	Laundry	28,317	14,320	41,077	83,714		83,714		83,714			4
5	Heat and Other Utilities			75,944	75,944		75,944	986	76,930			5
6	Maintenance	67,197	52,024	68,447	187,668		187,668	8,318	195,986			6
7	Other (specify):*			14,753	14,753		14,753	536	15,289			7
8	TOTAL General Services	328,014	280,599	209,534	818,147		818,147	8,231	826,378			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,365,967	83,000	3,813	1,452,780		1,452,780	(6,961)	1,445,819			10
10a	Therapy	7,476	2,858	1,204	11,538		11,538		11,538			10a
11	Activities	117,506	7,287	1,344	126,137		126,137		126,137			11
12	Social Services			1,762	1,762		1,762		1,762			12
13	CNA Training											13
14	Program Transportation			180	180		180		180			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,490,949	93,145	14,303	1,598,397		1,598,397	(6,961)	1,591,436			16
	C. General Administration											
17	Administrative	90,698		213,000	303,698		303,698	(102,114)	201,584			17
18	Directors Fees											18
19	Professional Services			86,747	86,747		86,747	(5,488)	81,259			19
20	Dues, Fees, Subscriptions & Promotions			55,077	55,077		55,077	(20,853)	34,224			20
21	Clerical & General Office Expenses	123,212	26,160	203,484	352,856		352,856	(150,495)	202,361			21
22	Employee Benefits & Payroll Taxes			502,024	502,024		502,024		502,024			22
23	Inservice Training & Education			2,521	2,521		2,521		2,521			23
24	Travel and Seminar							82	82			24
25	Other Admin. Staff Transportation			12,268	12,268		12,268	(4,133)	8,135			25
26	Insurance-Prop.Liab.Malpractice			90,038	90,038		90,038	1,667	91,705			26
27	Other (specify):*			4,263	4,263		4,263	25,364	29,627			27
28	TOTAL General Administration	213,910	26,160	1,169,422	1,409,492		1,409,492	(255,970)	1,153,522			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,032,873	399,904	1,393,259	3,826,036		3,826,036	(254,700)	3,571,336			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: WATERFRONT TERRACE **#0028076** **Report Period Beginning: 01/01/2005** **Ending: 12/31/2005**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	8,940	
	REPAIRS & MAINTENANCE		373	
			0	9,313
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		3,709	
	CONTRACTED LAUNDRY SERVICES		37,368	41,077
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		57,031	
	ELECTRICITY		9,074	
	WATER		9,839	
	CABLE TV - LOBBY		0	
			0	75,944
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		1,433	
	PAINTING & DECORATING		602	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		5,047	
	ELEVATOR MAINTENANCE & REPAIR		2,168	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		3,145	
	FIRE SERVICE		0	
	CONTRACTED BUILDING MAINTENANCE		56,052	
			0	
			0	68,447
7	**OTHER**			
	SCAVENGER		14,753	
	SECURITY SERVICE		0	14,753
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	6,000	6,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	3,813	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
			0	
			0	3,813
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES			
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	25	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	1,003	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	75	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	101	1,204
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	1,344	
			0	1,344
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	1,762	
			0	1,762
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number WATERFRONT TERRACE #0028076 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		180	180
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	213,000	213,000
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	3,657	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	79,143	
	COLLECTION FEES		3,947	86,747
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	19,719	
	EMPLOYEE WANT ADS	XIX F	22,852	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	5,242	
	LICENSES & PERMITS	XIX F	3,798	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	1,886	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	1,580	55,077
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		1,973	
	EQUIPMENT REPAIR & MAINTENANCE		16,864	
	OUTSIDE CLERICAL SERVICES		162,000	
	PENALTIES / OVERDRAFT CHARGES	VI 18	0	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		22,647	
	MESSENGER SERVICE		0	
			0	203,484

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	154,668	
	UNEMPLOYMENT COMPENSATION	XIX D	72,747	
	WORKERS COMPENSATION INSURANCI	XIX D	59,437	
	HOSPITALIZATION INSURANCE	XIX D	200,027	
	EMPLOYEE BENEFITS - OTHER	XIX D	10,201	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	4,944	502,024
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		2,521	2,521
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
			0	
			0	0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		12,268	12,268
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		90,038	90,038
27	**OTHER**			
	BAD DEBTS	VI 24	4,263	
				4,263

GRAND TOTAL COLUMN 3 OTHER 1,393,259

WATERFRONT TERRACE
EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
12/31/2005

TOTAL FOOD PURCHASE	157,310	PATIENT MEALS	110895
LESS SALES TAX	(503)	ADD EMPLOYEE MEALS	0
NET FOOD	156,807	TOTAL MEALS/YEAR	110895
TOTAL PATIENT CENSUS	36,965	NET FOOD	156807
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	110895
TOTAL PATIENT MEALS	110895	COST PER MEAL	1.41
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
TOTAL EMPLOYEE MEALS	0		

Facility Name & ID Number WATERFRONT TERRACE #0028076 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			77,038	77,038		77,038	59,374	136,412			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			33,517	33,517		33,517	116,986	150,503			32
33	Real Estate Taxes			108,538	108,538		108,538	2,640	111,178			33
34	Rent-Facility & Grounds			461,201	461,201		461,201	(461,201)				34
35	Rent-Equipment & Vehicles			6,951	6,951		6,951	4,405	11,356			35
36	Other (specify):*											36
37	**TOTAL Ownership**			687,245	687,245		687,245	(277,796)	409,449			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		77,868	241,319	319,187		319,187	(3,594)	315,593			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			64,605	64,605		64,605		64,605			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		77,868	305,924	383,792		383,792	(3,594)	380,198			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,032,873	477,772	2,386,428	4,897,073		4,897,073	(536,090)	4,360,983			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	50,744	30		9
10	Interest and Other Investment Income	(14,795)	32		10
11	Discounts, Allowances, Rebates & Refunds	(1,106)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(503)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties		21		18
19	Entertainment		20		19
20	Contributions	(1,886)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(3,965)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(4,263)	27		24
25	Fund Raising, Advertising and Promotional	(19,719)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(47,440)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (42,933)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(493,157)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (493,157)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (536,090)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

WATERFRONT TERRACE

ID# 0028076

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 0	6	1
2	MARKETING PROFESSIONAL SERVICE	(7,500)	19	2
3	MARKETING SALARY	(34,494)	21	3
4	MARKETING TRAVEL	(5,446)	25	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(47,440)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WATERFRONT TERRACE # 0028076 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,609)	0	0	0	0	0	0	0	0	0	0	(1,609)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	986	0	0	0	0	0	0	0	0	986	5
6	Maintenance	0	0	2,806	5,512	0	0	0	0	0	0	0	8,318	6
7	Other (specify):*	0	0	0	0	536	0	0	0	0	0	0	536	7
8	**TOTAL General Services**	(1,609)	0	3,792	5,512	536	0	0	0	0	0	0	8,231	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	(6,961)	0	0	0	0	0	(6,961)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	(6,961)	0	0	0	0	0	(6,961)	16
	C. General Administration													
17	Administrative	0	(213,000)	0	110,886	0	0	0	0	0	0	0	(102,114)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(11,465)	3,925	2,052	0	0	0	0	0	0	0	0	(5,488)	19
20	Fees, Subscriptions & Promotions	(21,605)	0	752	0	0	0	0	0	0	0	0	(20,853)	20
21	Clerical & General Office Expenses	(34,494)	(162,000)	39,931	6,068	0	0	0	0	0	0	0	(150,495)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	82	0	0	0	0	0	0	0	0	82	24
25	Other Admin. Staff Transportation	(5,446)	0	1,313	0	0	0	0	0	0	0	0	(4,133)	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,667	0	0	0	0	0	0	0	0	1,667	26
27	Other (specify):*	(4,263)	0	8,246	0	21,381	0	0	0	0	0	0	25,364	27
28	**TOTAL General Administration**	(77,273)	(371,075)	54,043	116,954	21,381	0	0	0	0	0	0	(255,970)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(78,882)	(371,075)	57,835	122,466	21,917	(6,961)	0	0	0	0	0	(254,700)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WATERFRONT TERRACE # 0028076 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	50,744	6,425	2,205	0	0	0	0	0	0	0	0	59,374	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(14,795)	129,316	2,465	0	0	0	0	0	0	0	0	116,986	32
33	Real Estate Taxes	0	0	2,640	0	0	0	0	0	0	0	0	2,640	33
34	Rent-Facility & Grounds	0	(461,201)	0	0	0	0	0	0	0	0	0	(461,201)	34
35	Rent-Equipment & Vehicles	0	0	4,405	0	0	0	0	0	0	0	0	4,405	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	35,949	(325,460)	11,715	0	0	0	0	0	0	0	0	(277,796)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	(3,594)	0	0	0	0	0	(3,594)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	(3,594)	0	0	0	0	0	(3,594)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(42,933)	(696,535)	69,550	122,466	21,917	(10,555)	0	0	0	0	0	(536,090)	45

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SCHEDULE ATTACHED		SCHEDULE ATTACHED		SCHEDULE ATTACHED		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEE	$ 213,000	DYNAMIC HEALTHCARE CONSULTANT		$	$ (213,000)	1
2	V	21	BOOKKEEPING SERVICES	162,000	" "			(162,000)	2
3	V								3
4	V								4
5	V								5
6	V								6
7	V	34	RENT	461,201	WATERFRONT TERRACE ASSOCIATES			(461,201)	7
8	V	30	DEPRECIATION		" "		6,425	6,425	8
9	V	19	ACCOUNTING & LEGAL		" "		3,925	3,925	9
10	V	32	INTEREST		" "		129,316	129,316	10
11	V								11
12	V								12
13	V								13
14	Total			$ 836,201			$ 139,666	$ * (696,535)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	DYNAMIC HEALTHCARE CONSULTANT	100.00%	$ 986	$ 986	15
16	V	6	REPAIR & MAINT.		" "		2,806	2,806	16
17	V	19	PROFESSIONAL FEES		" "		2,052	2,052	17
18	V	20	DUES AND SUBSCRIPTION		" "		752	752	18
19	V	21	CLERICAL & GENERAL		" "		39,931	39,931	19
20	V	24	SEMINARS AND TRAVEL		" "		82	82	20
21	V	25	AUTO EXPENSE		" "		1,313	1,313	21
22	V	26	INSURANCE		" "		1,667	1,667	22
23	V	27	EMP. BEN.- GEN, ADMIN.		" "		8,246	8,246	23
24	V	30	DEPRECIATION		" "		2,205	2,205	24
25	V	32	INTEREST		" "		2,465	2,465	25
26	V	33	REAL ESTATE TAXES		" "		2,640	2,640	26
27	V	35	EQUIPMENT RENTAL				4,405	4,405	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 69,550	$ * 69,550	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	MAINT. CMP.- D. NEHMER	$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$ 5,512	$ 5,512	15
16	V	17	ADMIN CMP.- M. MAUER		" "		15,215	15,215	16
17	V	17	ADMIN CMP.- M. AARON		" "		17,000	17,000	17
18	V	17	ADMIN CMP.- F. AARON		" "		15,064	15,064	18
19	V	17	ADMIN CMP.- S. GOLDSTEIN		" "				19
20	V	17	ADMIN CMP.- S. KOPLIN		" "		9,915	9,915	20
21	V	17	ADMIN CMP.- D. MAGAFAS		" "		10,464	10,464	21
22	V	17	ADMIN CMP.- S. LEVY		" "		14,164	14,164	22
23	V	17	ADMIN CMP.- HOWARD ALTER		" "		12,000	12,000	23
24	V	17	ADMIN CMP.- NON-OWNER		" "		17,064	17,064	24
25	V	21	CLERICAL. CMP. - S. AARON		" "		6,068	6,068	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 122,466	$ * 122,466	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	7	EMP. BEN. - D. NEHMER	$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$ 536	$ 536	15
16	V	27	EMP. BEN. - M. MAUER		" "		1,041	1,041	16
17	V	27	EMP. BEN. - M. AARON		" "		1,353	1,353	17
18	V	27	EMP. BEN. - F. AARON		" "		7,199	7,199	18
19	V	27	EMP. BEN. - S. GOLDSTEIN		" "				19
20	V	27	EMP. BEN. - S. KOPLIN		" "		3,471	3,471	20
21	V	27	EMP. BEN. - D. MAGAFAS		" "		847	847	21
22	V	27	EMP. BEN. - S. LEVY		" "		2,221	2,221	22
23	V	27	EMP. BEN. - H. ALTER		" "		1,105	1,105	23
24	V	27	EMP. BEN. - NON-OWNER		" "		2,800	2,800	24
25	V	27	EMP. BEN. - S. AARON		" "		1,344	1,344	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 21,917	$ * 21,917	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10a	THERAPY	$	DYNAMIC HEALTHCARE CONSULTANTS		$	$	15
16	V	19	PROFESSIONAL FEES		" "				16
17	V	22	EMPLOYEE BENEFITS		" "				17
18	V	39	ANCILLARY SERVICES		" "				18
19	V								19
20	V								20
21	V	10	MEDICAL SUPPLIES	23,872	LINCOLN MEDICAL SUPPLIES, INC		16,911	(6,961)	21
22	V	39	ANCILLARY SERVICES	12,325	" "		8,731	(3,594)	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 36,197			$ 25,642	$ * (10,555)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MARSHALL MAUER		ADMINISTRATION			SCHEDULE ATTACHED		SALARY	$ 15,215	17-7	1
2	MAURICE AARON		ADMINISTRATION					SALARY	17,000	17-7	2
3	FRED AARON		ADMINISTRATION					SALARY	15,064	17-7	3
4	FRED AARON		ADMINISTRATION					SALARY	6,000	12-1	4
5	SHARON AARON		CLERICAL					SALARY	6,068	21-7	5
6	HOWARD ALTER		ADMINISTRATOR					SALARY	12,000	17-7	6
7	HOWARD ALTER		ADMINISTRATOR					SALARY	90,698	17-1	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 162,045		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTHCARE CONSULTANTS
Street Address: 3359 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	TOTAL PATIENT DAYS	413,836	12	$ 11,039	$	36,965	$ 986	1
2	6	REPAIR & MAINT.	" "	413,836	12	31,419		36,965	2,806	2
3	19	PROFESSIONAL FEES	" "	413,836	12	22,969		36,965	2,052	3
4	20	DUES AND SUBSCRIPTION	" "	413,836	12	8,420		36,965	752	4
5	21	CLERICAL & GENERAL	" "	413,836	12	447,045	345,326	36,965	39,931	5
6	24	SEMINARS AND TRAVEL	" "	413,836	12	917		36,965	82	6
7	25	AUTO EXPENSE	" "	413,836	12	14,696		36,965	1,313	7
8	26	INSURANCE	" "	413,836	12	18,661		36,965	1,667	8
9	27	EMP. BEN.- GEN, ADMIN.	" "	413,836	12	92,321		36,965	8,246	9
10	30	DEPRECIATION	" "	413,836	12	24,690		36,965	2,205	10
11	32	INTEREST	" "	413,836	12	27,602		36,965	2,465	11
12	33	REAL ESTATE TAXES	" "	413,836	12	29,555		36,965	2,640	12
13	35	EQUIPMENT RENTAL	" "	413,836	12	49,319		36,965	4,405	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 778,653	$ 345,326		$ 69,550	25

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTHCARE CONSULTANTS
Street Address: 3359 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	MAINT. CMP. - D. NEHMER	WGHTD AVG. HOURS	40	12	$ 55,120	$ 55,120	4	$ 5,512	1
2	17	ADMIN CMP.- M. MAUER	" "	40	12	170,000	170,000	4	15,215	2
3	17	ADMIN CMP.- M. AARON	" "	40	12	170,000	170,000	4	17,000	3
4	17	ADMIN CMP.- F. AARON	" "	47	12	88,500	88,500	8	15,064	4
5	17	ADMIN CMP.- S. GOLDSTEIN	" "	45	12	24,000	24,000			5
6	17	ADMIN CMP.- S. KOPLIN	" "	40	12	72,485	72,485	5	9,915	6
7	17	ADMIN CMP.- D. MAGAFAS	" "	45	12	104,642	104,642	5	10,464	7
8	17	ADMIN CMP.- S. LEVY	" "	45	12	158,233	158,233	4	14,164	8
9	17	ADMIN CMP.- HOWARD ALTER	" "	40	12	12,000	12,000	40	12,000	9
10	17	ADMIN CMP.- NON-OWNER	" "	45	12	170,636	170,636	5	17,064	10
11	21	CLERICAL. CMP. - S. AARON	" "	40	12	67,785	67,785	4	6,068	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,093,401	$ 1,093,401		$ 122,466	25

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTHCARE CONSULTANTS
Street Address: 3359 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
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	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	7	EMP. BEN. - D. NEHMER	WGHTD AVG. HOURS	40	12	$ 5,362	$	4	$ 536	1
2	27	EMP. BEN. - M. MAUER	" "	40	12	11,631		4	1,041	2
3	27	EMP. BEN. - M. AARON	" "	40	12	13,532		4	1,353	3
4	27	EMP. BEN. - F. AARON	" "	47	12	42,295		8	7,199	4
5	27	EMP. BEN. - S. GOLDSTEIN	" "	45	12	33,649				5
6	27	EMP. BEN. - S. KOPLIN	" "	40	12	25,376		5	3,471	6
7	27	EMP. BEN. - D. MAGAFAS	" "	45	12	8,470		5	847	7
8	27	EMP. BEN. - S. LEVY	" "	45	12	24,807		4	2,221	8
9	27	EMP. BEN. - H. ALTER	" "	40	12	1,105		40	1,105	9
10	27	EMP. BEN. - NON-OWNER	" "	45	12	27,997		5	2,800	10
11	27	EMP. BEN. - S. AARON	" "	40	12	15,016		4	1,344	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 209,240	$		$ 21,917	25

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTHCARE CONSULTANTS
Street Address: 3359 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		DYNAMIC REHAB CONSULTANTS				$	$		$	1
2	10a	THERAPY	DIRECT ALLOCATION							2
3	19	PROFESSIONAL FEES	" "							3
4	22	EMPLOYEE BENEFITS	" "							4
5	39	ANCILLARY SERVICES	" "							5
6										6
7										7
8		LINCOLN MEDICAL SUPPLIES								8
9	10	MEDICAL SUPPLIES	DIRECT ALLOCATION			16,911			16,911	9
10	39	ANCILLARY SERVICES	" "			8,731			8,731	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 25,642	$		$ 25,642	25

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	BANK FINANCIAL		X	MORTGAGE	$36,603.24	10/99	$ 3,050,000	$	10/09	7.7500	$ 129,316	1
2												2
3												3
4	RELATED PARTY										2,465	4
5	BANK FINANCIAL		X	VAN LOAN							135	5
	Working Capital											
6	BANK FINANCIAL		X	WORKING CAPITAL				368,344		7.7500	28,115	6
7	INTERCOMPANY	X		WORKING CAPITAL							2,813	7
8			X	INSURANCE FINANCING							2,454	8
9	TOTAL Facility Related				$36,603.24		$ 3,050,000	$ 368,344			$ 165,298	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 3,050,000	$ 368,344			$ 165,298	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number WATERFRONT TERRACE **#** 0028076 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$	113,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	109,538	2
3. Under or (over) accrual (line 2 minus line 1).	$	(3,462)	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$	112,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	108,538	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2000	78,218	8
2001	80,252	9
2002	81,152	10
2003	107,158	11
2004	109,538	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2004 TAX BILL.

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WATERFRONT TERRACE COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0028076

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	21-30-412-045-0000	NURSING HOME	$ 108,795.54	$ 108,795.54
2.	21-30-412-038-0000	NURSING HOME	$ 742.30	$ 742.30
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 109,537.84	$ 109,537.84

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 37,824 B. General Construction Type: Exterior BRICK Frame STEEL & CONCRETI Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	37,824	1983	$ 100,000	1
2					2
3	TOTALS	37,824		$ 100,000	3

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1983		$ 1,508,000	$	35	$ 43,086	$ 43,086	$ 980,207	4
5											5
6											6
7											7
8	RELATED PARTY					1,016	1132		(1,016)		8
	Improvement Type**										
9	ROOF			1983	21,787		10			21,787	9
10	LEASEHOLD IMPROVEMENT			1985	950		15			950	10
11	LEASEHOLD IMPROVEMENT			1986	3,800	136	10		(136)	3,800	11
12	LEASEHOLD IMPROVEMENT			1986	1,005	11	15		(11)	1,005	12
13	ROOF			1990	13,634	433	10		(433)	13,634	13
14	SUSPENDED CEILING			1990	20,776	660	15	660		19,293	14
15	LEASEHOLD IMPROVEMENT			1991	7,956	253	10		(253)	7,956	15
16	LEASEHOLD IMPROVEMENT			1991	1,491	47	15	47		1,250	16
17	LEASEHOLD IMPROVEMENT			1992	18,033	572	10		(572)	18,033	17
18	LEASEHOLD IMPROVEMENT			1992	1,097	35	15	35		872	18
19	LEASEHOLD IMPROVEMENT			1993	7,742	246	31.5	246		3,126	19
20	LEASEHOLD IMPROVEMENT			1993	3,426	88	39	88		1,096	20
21	LEASEHOLD IMPROVEMENT			1994	25,007	642	39	642		7,355	21
22	ELEVATOR REPAIR			1995	1,500	39	39	39		416	22
23	SPRINKLER REPAIR			1995	4,154	107	39	107		1,154	23
24	BOILER REPAIR, WATER PUMP, ALARM			1996	6,033	154	39	154		1,496	24
25	FENCING			1996	756	50	15	50		475	25
26	NURSE STATION			1996	5,300	136	39	136		1,241	26
27	HANDRAILS			1996	3,735	96	39	96		868	27
28	PARKING LOT REPAVING			1997	14,968	998	15	998		7,580	28
29	TUCKPOINTING, ROOF REPAIR			1997	25,814	662	39	662		5,544	29
30	DRAPERY			1997	14,754	378	39	378		3,158	30
31	DOORS & SIGNS			1997	8,428	216	39	216		1,809	31
32	AIR HANDLER REPAIR & PUMPS			1997	17,005	436	39	436		3,652	32
33	REMODELING			1997	59,133	1,517	39	1,517		12,863	33
34	NURSE STATION			1997	5,106	131	39	131		1,097	34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	FLOOR TILES, HANDRAILS, BUMPERGUARDS	1998	$ 44,786	$ 1,148	39	$ 1,148	$	$ 8,552	37
38	RESIDENT ROOM SIGNS, DOORHOLDERS, DOOR MAGNET	1998	6,419	165	39	165		1,233	38
39	SPRINKLER WORK, ALARMS, SECURITY DOOR	1998	3,636	93	39	93		698	39
40	CUBICLE CURTAINS, WINDOW TREATMENTS	1998	8,000	205	39	205		1,529	40
41	BEAUTY SALON STATION	1998	2,042	52	39	52		380	41
42	REMODELING	1998	21,934	562	39	562		4,168	42
43	FENCING, LANDSCAPING	1998	5,089	339	15	339		2,542	43
44	GENERATOR, ELEVATOR REPAIR	1998	3,825	98	39	98		733	44
45	TUCKPOINTING, ROOF REPAIR	1998	21,000	538	39	538		4,000	45
46	ANTENNA & INSTALLATION	1998	17,323	444	39	444		3,295	46
47	LIGHT FIXTURES, ARTWORK	1998	10,050	259	39	259		1,919	47
48	FIRE ALARM	1999	10,286	264	39	264		1,768	48
49	BATHROOMS REMODELING	1999	35,657	914	39	914		6,074	49
50	BOILER WORK	1999	7,345	188	39	188		1,257	50
51	CABLE WORK	1999	433	11	39	11		75	51
52	CARPET	1999	18,828	483	39	483		3,184	52
53	ELEVATOR WORK	1999	2,017	52	39	52		347	53
54	AIR CONDITIONING	1999	7,350	189	39	189		1,285	54
55	LIGHT AND MIRRORS	1999	9,093	233	39	233		1,512	55
56	ROOF WORK	1999	2,187	56	39	56		366	56
57	ROOMS IMPROVEMENTS	1999	59,493	1,525	39	1,525		9,682	57
58	WINDOWS	1999	5,513	141	39	141		932	58
59	RELATED PARTY - NURSE CALL SYSTEM	1999	32,456	833	39	833		5,378	59
60	RELATED PARTY - NURSE STATION	1999	19,656	504	39	504		3,255	60
61	RELATED PARTY - DRYWALL, PAINT, FLOORING	1999	176,452	4,524	39	4,524		29,221	61
62	RELATED PARTY - FIRE SYSTEM DAMPERS	1999	22,000	564	39	564		3,644	62
63	NURSE CALL SYSTEM	2000	2,778	102	27.5	102		562	63
64	BATHROOM REMODELING	2000	10,080	367	27.5	367		2,062	64
65	FIRE ALARM REPAIR	2000	3,170	115	27.5	115		651	65
66	WALL TILES/FLOORING/KICKPLATES/BASEBOARD	2000	10,242	372	27.5	372		2,087	66
67	DRYWALL & CEILING REPAIR	2000	79,500	2,891	27.5	2,891		16,171	67
68	1ST FLOOR REMODEL	2000	2,698	98	27.5	98		540	68
69	DOOR/DOORBELL INTERCOM/PAGER	2000	2,640	96	27.5	96		530	69
70	TOTAL (lines 4 thru 69)		$ 2,465,368	$ 27,484		$ 68,149	$ 40,665	$ 1,241,349	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,465,368	$ 27,484		$ 68,149	$ 40,665	$ 1,241,349	1
2	EXHAUST FAN	2000	890	32	27.5	32		185	2
3	HOT WATER HEATER	2000	1,100	40	27.5	40		227	3
4	OVERBED LIGHTS	2000	3,093	112	27.5	112		636	4
5	WINDOW TREATMENTS/CUBICLE CURTAINS	2000	11,247	1,607	7	1,607		10,183	5
6	ROOF REPAIRS	2001	7,445	271	27.5	271		1,294	6
7	LOCKS, DOORS, NURSE STATION MONITOR	2001	6,180	225	27.5	225		1,052	7
8	OUTLETS, TRANSFERSWICH	2001	5,686	207	27.5	207		965	8
9	VALVES, BASEMENT REPAIR	2001	6,136	223	27.5	223		1,044	9
10	LIGHT FIXTURES	2001	2,450	89	27.5	89		414	10
11	AC UNIT	2001	786	28	27.5	28		128	11
12	BOILER/WATER TOWER REPAIR	2002	5,055	276	27.5	276		966	12
13	ELEVATOR REPAIR	2002	6,244	135	27.5	135		450	13
14	FIRE SAFETY EQUIPMENT	2003	2,468	90	27.5	90		221	14
15	ELEVATOR REPAIR	2003	3,980	145	27.5	145		356	15
16	HEATING REPAIRS	2003	1,930	70	27.5	70		173	16
17	GENERATOR REPAIRS	2003	71,609	2,604	27.5	2,604		6,401	17
18	DECK & FENCE	2004	10,197	680	15	680		1,020	18
19	A/C REPAIR	2004	2,200	79	27.5	80	1	116	19
20	SMOKE DETECTORS & FIRELITE MODULES	2004	4,484	164	27.5	163	(1)	238	20
21	WATER HEATER	2004	6,937	253	27.5	252	(1)	368	21
22	NURSE CALL STATION	2004	585	21	27.5	21		31	22
23	GENERATOR REPAIRS	2004	1,250	45	27.5	45		66	23
24	FIRE ALARM REPAIR, FACP DOORS	2005	37,659	628	27.5	628		628	24
25	BOILER, PLUMBING & PIPING	2005	16,751	279	27.5	279		279	25
26	NURSE CALL SYSTEM	2005	19,432	323	27.5	324	1	324	26
27	AIR CONDITIONER 10,000 BTU	2005	12,907	215	27.5	215		215	27
28	ROOF REPAIRS	2005	726	12	27.5	12		12	28
29	ELECTRIC WIRING	2005	4,400	73	27.5	73		73	29
30	CUBICLE CURTAINS	2005	1,020	17	27.5	17		17	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,720,215	$ 36,427		$ 77,092	$ 40,665	$ 1,269,431	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 565,261	$ 40,490	$ 52,003	$ 11,513	7-20	$ 322,709	71
72	Current Year Purchases	30,330	5,843	1,516	(4,327)	10	1,516	72
73	Fully Depreciated Assets	327,988					327,988	73
74	RELATED PARTY		196	1,779	1,583			74
75	TOTALS	$ 923,579	$ 46,529	$ 55,298	$ 8,769		$ 652,213	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		USED VEHICLE	2002	$ 14,925	$ 1,719	$ 2,985	$ 1,266	5	$ 8,955	76
77										77
78	RELATED PARTY				993	1,037	44			78
79										79
80	TOTALS			$ 14,925	$ 2,712	$ 4,022	$ 1,310		$ 8,955	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,758,719	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 85,668	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 136,412	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 50,744	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,930,599	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NA
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 4,089 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17		2001 HONDA	$ 429.00	$ 5,148	17
18			FRINGE BENEFIT	(2,286)	18
19					19
20					20
21	TOTAL		$ 429.00	$ 2,862	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 142,513	$		$ 142,513	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			4,009			4,009	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			94,797			94,797	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				56,037		56,037	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	SUPPLIES, RADIOL, LAB, RENTAL Other (specify):	39.2					21,831		21,831	13
14	TOTAL			$		$ 241,319	$ 77,868		$ 319,187	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number WATERFRONT TERRACE **#** 0028076 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2005 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (60,420)	814,820		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	51,845		6
7	Other Prepaid Expenses	4,500		7
8	Accounts Receivable (owners or related parties)	112,564		8
9	Other(specify): R E TAX ESCROW	49,552		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,033,281	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	961,650		15
16	Equipment, at Historical Cost	938,502		16
17	Accumulated Depreciation (book methods)	(1,086,180)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): DEPOSIT	26,049		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 840,021	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,873,302	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 482,288	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	368,344		29
30	Accrued Salaries Payable	166,139		30
31	Accrued Taxes Payable (excluding real estate taxes)	20,758		31
32	Accrued Real Estate Taxes(Sch.IX-B)	112,000		32
33	Accrued Interest Payable	3,204		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,152,733	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,152,733	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 720,569	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,873,302	$	48

***(See instructions.)**

Facility Name & ID Number WATERFRONT TERRACE **#** 0028076 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 747,196	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 747,196	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	53,373	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(80,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (26,627)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 720,569	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,747,574	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,747,574	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	186,971	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 186,971	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	14,795	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 14,795	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	DISCOUNTS EARNED	1,106	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,106	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,950,446	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	818,147	31
32	Health Care	1,598,397	32
33	General Administration	1,409,492	33
	B. Capital Expense		
34	Ownership	687,245	34
	C. Ancillary Expense		
35	Special Cost Centers	319,187	35
36	Provider Participation Fee	64,605	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,897,073	40
41	**Income before Income Taxes (line 30 minus line 40)****	53,373	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 53,373	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,827	2,097	$ 67,272	$ 32.08	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,718	1,744	46,950	26.92	3
4	Licensed Practical Nurses	30,325	33,748	694,445	20.58	4
5	CNAs & Orderlies	53,763	57,677	499,103	8.65	5
6	CNA Trainees					6
7	Licensed Therapist	283	283	7,476	26.42	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,899	2,070	29,352	14.18	9
10	Activity Assistants	8,908	9,598	88,154	9.18	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,249	1,429	21,573	15.10	13
14	Head Cook	5,779	6,393	62,356	9.75	14
15	Cook Helpers/Assistants	10,096	10,977	107,121	9.76	15
16	Dishwashers					16
17	Maintenance Workers	4,254	4,625	67,197	14.53	17
18	Housekeepers	5,291	5,452	41,450	7.60	18
19	Laundry	3,000	3,250	28,317	8.71	19
20	Administrator	1,941	2,211	90,698	41.02	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,664	7,056	123,212	17.46	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,962	2,132	22,240	10.43	31
32	Other Health Care(specify)	1,558	1,823	35,957	19.72	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	140,517	152,565	$ 2,032,873 *	$ 13.32	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 8,940	1-3	35
36	Medical Director		6,000	9-3	36
37	Medical Records Consultant		0	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant		3,813	10-3	39
40	Physical Therapy Consultant		25	10a-3	40
41	Occupational Therapy Consultant		1,003	10a-3	41
42	Respiratory Therapy Consultant		75	10a-3	42
43	Speech Therapy Consultant		101	10a-3	43
44	Activity Consultant	28	1,344	11-3	44
45	Social Service Consultant	33	1,762	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	61	$ 23,063		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Certified Nurse Assistants/Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
HOWARD ALTER	ADMIN		$ 90,698
			0
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 90,698

B. Administrative - Other

Description	Amount
MANAGEMENT FEES	$ 213,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 213,000

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		86,747
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 86,747

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 59,437
Unemployment Compensation Insurance	72,747
FICA Taxes	154,668
Employee Health Insurance	200,027
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	10,201
CHICAGO HEAD TAX	4,944
TOTAL (agree to Schedule V, line 22, col.8)	$ 502,024

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 2,187
Advertising: Employee Recruitment	22,852
Health Care Worker Background Check	1,580
(Indicate # of checks performed 41)	
MARKETING/ADV/PROMO	19,719
TRUST/FRANCHISE/CONTRIB/ETC	1,886
LICENSES & PERMITS	1,611
DUES & SUBSCRIPTIONS	5,242
MGMT CO ALLOCATION	752
TRUST/FRANCHISE/CONTRIB/ETC	(1,886)
Less: Public Relations Expense	(0)
Non-allowable advertising	(19,719)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 34,224

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
MGMT CO ALLOCATION	82
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 82

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	PAINT/DECORATING		$		$	$	$	$	$	$	$	$	$
2													
3								N/A					
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number WATERFRONT TERRACE # 0028076 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount. **IL COUNCIL ON LONG TERM CARE $4,995**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **YES** If YES, have these costs
been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **7,243** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease. **NO**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen
during this cost report period. $ **64,605**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed tc
the Department, in addition to the daily rate, been properly classifiec
in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services fo
the patient census listed on page 2, Section B? **NO** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **0** Has any meal income been offset against
related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo
residents? **NO** If YES, please indicate the amount of income earned from such a
program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all othe
times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out
out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees